
REVISION DATES: 07/26/2016; 06/30/2016; 05/23/2016; 12/21/2015; 08/14/2014

The covered services, limitations, and exclusions described in this chapter are global in Nature and are listed here to offer general guidance to acute care hospitals. Specific Questions regarding covered services, limitations, and exclusions should be addressed to the AHCCCS Office of Medical Policy and Coding at (602) 417-4066. The *AHCCCS Medical Policy Manual (AMPM)* is available on the AHCCCS web site at:

www.azahcccs.gov.

Inpatient Hospital Services

AHCCCS covers medically necessary inpatient hospital services provided by or under the direction of a physician which are ordinarily furnished in a hospital, except for services in an institution for tuberculosis or mental diseases. Inpatient services at Indian Health Service (IHS) and 638 tribal hospitals are covered for AHCCCS/ALTCS recipients when the recipient's condition requires hospitalization because of the severity of illness and intensity of services required.

Covered hospital accommodation services include:

- Maternity care
- Medical/surgical care unit
- Nursery and neonatal intensive care nursery
- Intensive care and coronary care unit
- Nursing services necessary and appropriate for the recipient's condition
- Dietary services
- Medical supplies, appliances, and equipment ordinarily furnished to hospital inpatients that are billed as part of the daily room and board charge

Covered ancillary services include:

- Labor, delivery, observation rooms, and birthing centers
- Procedure, operating, and recovery rooms
- Perfusion services
- Laboratory services
- Radiology and medical imaging services

- Anesthesiology services
- Rehabilitation services, including physical, occupational, and speech therapies
- Pharmaceutical services and prescribed drugs
- Respiratory therapy
- Services and supplies necessary to store, process, and administer blood and blood derivatives
- Central supply items, appliances, and equipment ordinarily furnished to all patients and customarily reimbursed as ancillary services
- Maternity services
- Nursery and related services
- Chemotherapy
- Dialysis
- Total parenteral nutrition services (TPN)
- Dental surgery for EPSDT recipients

Exclusions and limitations:

Inpatient dialysis treatments are covered only when the hospitalization is for:

- An acute medical condition requiring hemodialysis treatments.
- A medical condition experienced by a recipient routinely maintained on an outpatient chronic dialysis program.
- Placement, replacement, or repair of the chronic dialysis route (shunt or cannula).

Personal comfort items are not covered.

Professional services rendered during an inpatient stay must be billed separately on a CMS 1500 claim form.

Effective from 10/1/2011 through 9/30/2014 for recipients 21 years of age or older, coverage of in-state and out-of-state inpatient hospital services is limited to 25 days per benefit year. The benefit year is a one year time period of October 1st through September 30th. This limit applies for all inpatient hospital services with dates of service during the benefit year regardless of whether the recipient is enrolled in Fee for Service, is enrolled with one or more contractors, or both, during the benefit year.

Counting the annual 25 inpatient day limit

Inpatient days are counted towards the 25 day limit if paid in whole or part by the Administration or a contractor; in the order of the adjudication date of a paid claim.

Paid inpatient days are allocated to the benefit year in which the date of service occurs.
(A.A.C. R9-22-204 C)

Each 24 hours of paid observation services will count as one inpatient day if the patient is not admitted to the same hospital directly following the observation services. Observation services which are directly followed by an inpatient admission to the same hospital are not counted towards the inpatient limit.

After 25 days of inpatient hospital services have been paid as provided for in this policy, outpatient services that are directly followed by an inpatient admission to the same hospital, including observation services, are not covered.

Continuous periods of observation service lasting less than 24 hours that are not directly followed by an inpatient admission to the same hospital are covered.

For continuous periods of observation services of more than 24 hours that are not directly followed by an inpatient admission to the same hospital, AHCCCS will only pay for the first 23 hours of observation services.

For purposes of counting the annual 25 inpatient day limit the following exclusions apply:

Transplants

Days reimbursed under specialty contracts between the Administration and a transplant facility that are included within the component pricing referred to in the contract.

Examples include the following:

1. Evaluation (limited to inpatient days directly associated with the evaluation)
2. Tissue harvesting for autologous bone marrow transplants and the related costs/inpatient days for live donors are part of the exclusion.
Note: If the donor is a Medicaid recipient, this will not be included as part of the donor's 25 day limit.
3. Total Body Irradiation (limited to the inpatient days associated with the series of conditioning regimens prior to bone marrow or peripheral blood stem cell transplantation)

4. Preparation and transplant
5. Post transplant care (10 days post transplant care for kidney transplants; up to 60 days for other covered transplants)
6. Placement of Circulatory Assist Devices (CAD) also known as Ventricular Assistive Devices (VAD) and Total Artificial Hearts (TAH) limited to day of surgery. Inpatient days before and after the placement of the CADs are to be counted towards the annual 25 inpatient day limit.

NOTE: Inpatient days while “wait listed” are to be counted towards the 25 day limit. This is the period of time after a recipient has been determined to be a candidate for transplant, by the transplant facility, and is waiting for an available organ.

Behavioral Health

Inpatient days that qualify for the Psychiatric Tier under R9-22-712.09 and reimbursed by the Administration or its contractors are excluded from the 25 inpatient day limit including:

1. Inpatient days with a primary psychiatric diagnosis code reimbursed by the Administration or its contractors.
2. Inpatient days paid by the Arizona Department of Health Services Division of Behavioral Health Services or a RBHA or TRBHA.

Burn Diagnoses

Days related to treatment of conditions with diagnoses of burns or burn late effect at a governmentally-operated hospital located in an Arizona county with a population of more than 500,000 persons with a specialized burn unit in existence prior to 10/1/2011 are excluded from the 25 inpatient day limit.

Same Day Admit/Discharge services are excluded from the 25 inpatient day limit.

Health Care Acquired Conditions and Other Provider-Preventable Conditions

42 CFR Section 447.26 prohibits payment for services related to Provider-Preventable Conditions. A Provider-Preventable Condition means a condition that meets the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC) as defined:

Health Care-Acquired Condition (HCAC) – means a Hospital Acquired Condition (HAC) under the Medicare program which occurs in any inpatient setting and which is not present on admission. (*Refer to the AMPM Chapter 900, Policy 960-E*)

Other Provider-Preventable Condition (OPPC) – means a condition occurring in the inpatient and outpatient health care setting which AHCCCS has limited to the following:

1. Surgery on the wrong recipient,
2. Wrong surgery on a recipient and
3. Wrong site surgery.

A recipient's health status may be compromised by hospital conditions and/or medical personnel in ways that are sometimes diagnosed as a "complication". If it is determined that the complication resulted from an HCAC or OPPC, any additional hospital days or other additional charges resulting from the HCAC or OPPC will not be reimbursed.

If it is determined that the **HCAC** or **OPPC** was a result of mistake or error by a hospital or medical professional, the AHCCCS Medical Review Unit will report the occurrence to the AHCCCS Clinical Quality Management Unit.

Billing an Inpatient Claim

Inpatient hospital claims from IHS and 638 tribal facilities must be submitted to the AHCCCS Administration on UB-04 claim forms (See Chapter 5, Claim Form Requirements for UB-04 billing instructions).

Inpatient services for Title XIX (Medicaid) and Title XXI (KidsCare) recipients are billed with two revenue codes:

100 – All-inclusive Room and Board

001 – Total Charges

IHS/638 facilities approved for an NICU rate with AHCCCS must use NICU revenue codes to bill for NICU services.

All UB04 data fields must be completed as appropriate.

Effective with date of discharge 01/01/2016 the attending provider's NPI must be included on the UB-04 billing. The attending provider must be an active AHCCCS registered provider.

Reimbursement of Inpatient Hospital Claims

AHCCCS pays for the date of admission up to but not including date of discharge unless the patient expires.

Example 1:

Dates of service: 03/05 through 03/10 Accommodation days billed: 5

Bill type: 111 Patient status: 01

AHCCCS will reimburse five days. The date of discharge will not be paid when the patient status indicates a status other than expired.

Example 2:

Dates of service: 03/05 through 03/10 Accommodation days billed: 6

Bill type: 111 Patient status: 20

AHCCCS will reimburse six days because the patient status indicates expired.

Example 3:

Dates of service: 03/25 through 03/31 Accommodation days billed: 6

Bill type: 112 Patient status: 30

AHCCCS will reimburse six days. AHCCCS will pay the last accommodation day billed when the patient status is 30 (still a patient – first interim billing).

Example 4:

Dates of service: 03/05 through 03/10 Accommodation days billed: 2

Bill type: 111 Patient status: 01

AHCCCS will reimburse two days. The provider billed only two accommodation days. AHCCCS will reimburse the number of accommodation days billed up to the maximum allowed for the dates of service.

When a patient is admitted and discharged on the same day, AHCCCS will reimburse the claim as follows:

1. Same day admit/transfer:

If the transferring hospital is an IHS/638 facility the reimbursement will be at the outpatient All Inclusive Rate (AIR).

The receiving hospital would be paid the full per diem payment for the date of transfer provided the hospital bills for at least one accommodation day.

2. Same day admit/discharge:

The IHS/638 facility will be reimbursed at the outpatient All Inclusive Rate (AIR)

If the hospital bills as an inpatient admission and the AHCCCS system would qualify the claim as Maternity or Nursery tier, reimbursement will be at the inpatient All Inclusive Rate (AIR).

3. Same day admit/patient expires:

The IHS/638 facility will be reimbursed at the inpatient All Inclusive Rate (AIR).

AHCCCS reimburses inpatient claims from IHS and 638 tribal facilities as follows:

Federally published All Inclusive Rate as established by the federal Office of Management and Budget (OMB)

When Medicare is the primary payer and has made payment on the claim AHCCCS will reimburse the Medicare coinsurance and/or deductible when appropriate. (refer to Chapter 7 Medicare/Other Insurance for further information).

Outpatient Facility Services

AHCCCS covers preventive, diagnostic, rehabilitative, and palliative services or items ordinarily provided on an outpatient basis for all recipients within certain limits based on recipient age and eligibility.

Covered outpatient services include:

- Medically necessary outpatient hospital and clinic services
- Emergency room services
- Ambulatory surgery center (ASC) services
- Laboratory services
- Medical supplies and equipment ordinarily furnished to persons receiving outpatient services to the extent that they are covered services and ordered by a physician
- Pharmaceutical services and prescribed drugs
- Radiology and medical imaging services
- Physician services (including ambulatory surgery, specialty care, and home visits)
- Nurse midwife services
- Dental surgery for EPSDT eligible recipients
- Rehabilitation services, excluding occupational therapy and speech therapy for recipients 21 years of age or older
- Services of allied health professionals when referred by or under the supervision of a physician
- Dialysis
- Total parenteral nutrition (TPN) services

If a recipient is treated in the emergency room, observation area, or other outpatient department and is directly admitted to the same hospital, then services for the emergency room, observation, or other outpatient charges must be billed on the inpatient claim.

Billing and Reimbursement of Outpatient Services for Title XIX (Medicaid)

IHS/638 tribal **hospital outpatient surgery claims** for **Title XIX (Medicaid)** recipients are billed on the 1500 claim form (837P for electronic claims).

Use the appropriate surgical CPT code(s).

- The AHCCCS Claims System will price the procedure at the appropriate AHCCCS ASC Fee Schedule amount accordingly.
- The surgeon and anesthesiologist may bill for services on the CMS 1500 claim form. (837P for electronic claims). (See Chapter 8, Individual Practitioner Services). These claims are reimbursed at the lesser of billed charges or the AHCCCS capped fee.

Outpatient Pharmacy

IHS/638 facility Pharmacy outpatient services for **Title XIX (Medicaid)** recipients are billed on a UB-04 claim form (837I for electronic claims) using the appropriate pharmacy clinic revenue code 0519.

Effective with date of service 01/01/2016 the facility's NPI must be billed as the attending provider on the UB-04, as AHCCCS does not register pharmacists.

Effective with date of service 07/01/2016 all pharmacy claims billed on a UB-04 with revenue code 0519 must be billed with the National Drug Code (NDC) for each medication and vaccine. For detailed billing information refer to the NDC resource documents available on the AHCCCS website at:

<https://www.azahcccs.gov/AmericanIndians/Providers>

and Chapter 5 Claim Form Requirements.

The outpatient IHS/638 all-inclusive rate is billable for a pharmacy clinic consult visit when the pharmacist, or an intern under the supervision of a pharmacist, counsels the patient at the point of picking up the medication(s).

Each clinic pharmacy consultation visit billed to AHCCCS must be supported by pharmacy records including, but not limited to, the patient's dated signature and their prescription profile to support the date of consultation at the pharmacy.

The Initial Pharmacy Consultation service includes the cost of medication. Reimbursement for pharmacy consultation services is only available on a day when medication is dispensed. Refills at the facility for prescribed medications after the initial Pharmacy Consultation are reimbursable as a pharmacy encounter under this same methodology

when the pharmacist, or an intern under the supervision of a pharmacist, counsels the member at the point of medication pick up at the pharmacy.

For recipients eligible for Medicare Part D coverage, the pharmacy service cannot be billed to AHCCCS for any medications covered by the Part D plan, including Part D copays. (refer to Chapter 7 Medicare for further details and the AHCCCS Pharmacy web page <https://www.azahcccs.gov/Resources/Downloads/PharmacyUpdates/AHCCCSDualFormulary.pdf> for the AHCCCS Drug List [ADL] for Duals)

Adult (age 21 and older) seasonal flu and pneumococcal vaccines administered by the facility's pharmacist are also considered a pharmacy outpatient service when administered by a pharmacist who is licensed and certified by the Arizona State Board of Pharmacy consistent with the limitations of this policy and state law ARS §32-1974.

AHCCCS allows one outpatient pharmacy clinic encounter per recipient, per date of service regardless of the number of pharmacy services during the encounter. (Note: the number of clinic visits per recipient, per date of service is limited to 5, one of which can be the outpatient pharmacy clinic visit.)

Date of service for a pharmacy outpatient clinic visit is defined as:

- the date of the face-to-face encounter for the medication counseling as supported by the recipient's dated signature;
- the date the pharmacist administered the adult vaccine(s);
- the date of the face-to-face encounter for anti-coagulant therapy management

The date of service must be supported in the pharmacy records by the recipient's dated signature at the time of the consultation in the pharmacy.

The AHCCCS Claims System will reimburse the service at the outpatient all inclusive rate (AIR) as established annually by the federal Office of Management and Budget (OMB). A pharmacy outpatient clinic visit is eligible for reimbursement at the AIR so long as an AHCCCS covered service has been provided during the visit and all other criteria is met.

Other Outpatient Hospital and Clinic Services

All **other hospital** and **clinic outpatient services** for **Title XIX (Medicaid)** recipients are billed on a UB-04 claim form (837I for electronic claims) using the appropriate clinic revenue code (0510 for medical; 0512 for dental).

Effective with date of service 01/01/2016 the attending provider's NPI must be billed on the UB-04. The attending provider must be an active AHCCCS registered provider on the date of service.

An outpatient clinic service (revenue code 0510 or 0512) is eligible for reimbursement at the All Inclusive Rate (AIR) so long as an AHCCCS covered service has been provided during the visit and all other criteria are met.

Effective with date of service 01/01/2016, the IHS/Tribal facility has the option to breakout Emergency Department services by billing with revenue code 0516 and must include the ED attending provider's NPI. Billing the ED services with revenue code 0516 (rather than using the clinic code 0510) will allow for more accurate data reporting to help inform care coordination efforts for the recipients. There will be no edits placed to deny for incorrect place of service for revenue code 0516.

Use bill type 131 (Hospital outpatient, admit through discharge) or 711 (Clinic, rural health, admit through discharge).

Enter the outpatient all inclusive rate (AIR) rate in the Total Charges field.

The AHCCCS Claims System will reimburse the service at the outpatient all inclusive rate (AIR) as established annually by the federal Office of Management and Budget (OMB).

The federal OMB **all inclusive rate (AIR)** encompasses all services performed and/or ordered during the clinic visit including labs, x-ray and imaging. The technical component (-TC) cannot be billed separately. (A "Stand Alone Visit" is a visit (encounter) that occurs in conjunction with a clinic visit, either before or after that clinic visit, but on a separate day. As a matter of policy AHCCCS does not reimburse Stand Alone Visits for lab services.)

A clinic visit is inclusive of all services provided in conjunction with the visit and includes any laboratory service that may be performed on the same day, before, or after the clinic visit. The AIR that is paid for the clinic visit (encounter) includes the laboratory services done on the same day or any other day.

A lab test that is ordered during a clinic visit but is done on another day is not considered an "Orphan Visit" and cannot be billed separately. For example: during a billable clinic visit a lab test is ordered for that day's assessment. For whatever reason, the lab work is not done the same day as the clinic visit. Documentation should reflect one single visit for the clinic and ordered lab work and therefore one billable All Inclusive Rate (AIR) encounter.

An "Orphan Visit" is a planned laboratory visit based on the provider's care plan, i.e. a new medication and a laboratory assessment is required after treatment initiation.

Since this Orphan Visit is a planned laboratory visit, the patient is checked in, a visit is created and the labs are performed. Documentation must reflect this is an Orphan Visit and must be supported in the provider's care plan. The Orphan Visit can be billed separately as an outpatient claim, reimbursable at the AIR and is counted as one of the allowable visits per day.

AHCCCS does reimburse for Stand Alone Visits for radiology and medical imaging professional services. AHCCCS registered radiologists may bill for their interpretation services on a CMS 1500 claim form with HCPCS/CPT codes and modifier -26.

Billing and Reimbursement of Outpatient Services for Title XXI (KidsCare)

Claims for KidsCare must be submitted to the member's **enrolled health plan**. If the KidsCare member is enrolled in a managed care plan, submit the claim to that plan. If the KidsCare member is enrolled as FFS or AIHP, then submit the claim to AHCCCS.

IHS/638 tribal **hospital outpatient surgery claims** for **Title XXI (KidsCare)** recipients are billed on the 1500 claim form (837P for electronic claims) with appropriate CPT/HCPCS codes. Claims are reimbursed at the AHCCCS ASC Fee Schedule amount accordingly.

The surgeon and anesthesiologist may bill for services on the CMS 1500 claim form. (837P for electronic claims). (Refer to Chapter 8, Individual Practitioner Services). These claims are reimbursed at the lesser of billed charges or the AHCCCS capped fee schedule.

All **other hospital outpatient services** for **Title XXI (KidsCare)** recipients are billed on the UB-04 claim form (837I for electronic claims) with appropriate revenue codes.

Effective with date of service 01/01/2016 the attending provider's NPI must be billed on the UB-04. The attending provider must be an active AHCCCS registered provider on the date of service.

Claims are reimbursed at the Outpatient Fee Schedule (OPFS) rate.

All **other clinic outpatient services** for **Title XXI (KidsCare)** recipients are billed by the individual practitioner (physician, nurse practitioner, etc.) on the CMS 1500 with HCPCS/CPT codes. Claims are reimbursed at the lesser of billed charges or the AHCCCS capped fee.

Outpatient **dental services** for **Title XXI (KidsCare)** recipients are billed by the individual practitioner dentist on the ADA 2012 claim form with CDT-4 codes. Claims are reimbursed at the lesser of billed charges or the AHCCCS capped fee.

Billing for Observation Services

Observation services are those reasonable and necessary services provided on a hospital's premises for evaluation until criteria for inpatient hospital admission or discharge/transfer have been met. Covered observation services include:

- Use of a bed
- Periodic monitoring by the hospital's nursing staff or, if appropriate, other staff necessary to evaluate, stabilize, or treat medical conditions of a significant degree of instability and/or disability on an outpatient basis

Refer to the Inpatient Hospital Services Exclusions and Limitations section on page 9-3 of this policy, for further guidance regarding observation services for recipients who have received greater than 25 inpatient days.

Observation stays must be provided in a designated "observation area" of the hospital unless such an area does not exist.

IHS and 638 tribal hospitals must bill for observation services for **Title XIX (Medicaid)** recipients on the UB-04 claim form (837I for electronic claims) following the instructions for other outpatient services above. AHCCCS will reimburse the observation services at the outpatient AIR rate.

IHS and 638 tribal hospitals must bill for observation services for **Title XXI (KidsCare)** recipients on the UB-04 claim form and must bill with 762 revenue code (Treatment/Observation Room - Observation Room).

Effective with date of discharge 01/01/2016 the attending provider's NPI must be included on the UB-04. The attending provider must be an active AHCCCS registered provider.

AHCCCS defines a "unit" of observation service as each hour or portion of an hour that a recipient is in observation status.

For example:

A recipient is placed in observation status at 2:25 p.m. and sent home at 7:45 p.m. The hospital would submit a UB-04 claim to AHCCCS as follows:

Revenue Code	762
Units to bill:	6

Each unit of observation services equals one hour or portion of an hour. The recipient was in observation status for five hours and 20 minutes, which equals six units.

Observation services that directly precede an inpatient admission to the same hospital must not be billed separately. These charges must be billed on the inpatient claim. The inpatient claim is priced at the inpatient All Inclusive Rate based on the number of allowed accommodation days. Reimbursement for the observation services provided before the hospital admission is included in the inpatient AIR payment.

Group Billing

IHS and 638 tribal hospitals and clinics may register as group billers and bill as an agent for physicians and mid-level practitioners.

In these cases, the claim will carry both the physician/mid-level practitioner ID as the service provider and the hospital or clinic group biller ID.

See Chapter 3, Provider Records and Registration, for information on registering as a group biller, or the AHCCCS website for Provider Registration at:

<https://www.azahcccs.gov/PlansProviders/NewProviders/registration.html>

Revision/Update History

Date	Description of changes	Page(s)
07/26/2016	Added clarification for where to submit KidsCare claims	12
06/30/2016	Added web link to NDC references and resources for billing information	9
05/23/2016	Added clarification: pharmacy clinic visit attending provider must be facility's NPI, not the pharmacist's as initially advised	9
	Added NDC required beginning with date of service 07/01/2016	9
	Updated web address for AHCCCS Duals Drug list	10
	Added clarification: pharmacist must be licensed and certified in AZ for adult immunizations to administer without a prescription order on file	10
	Clarification language added re: AIR eligible reimbursement for covered service	10
	Updated web address for Group Billing information	14
12/21/2015	"Attending Provider" language added as UB-04 billing requirement effective with date of service or date of discharge 01/01/2016 attending provider NPI required	6, 9, 11, multiple
	Added new section header for Title XIX;	9
	Language clarified " <u>eligible</u> for Part D";	9
	Clarified pharmacy encounter visit limit	9
	Removed language for adult seasonal flu/pneumo vaccines re: physician order must be on file	10
	Added optional breakout billing for ED services effective with service date 01/01/2016	10
	Language clarified for pharmacy encounter "date of service".	11
	Added new section header for KidsCare;	11
	Corrected the KidsCare outpatient hospital reimbursement language	11
	New document layout/formatting	all
8/14/2014	Added clarification for adult seasonal flu and pneumococcal vaccines administered by the pharmacist, physician order must be on file	9
1/24/2014	Added "perfusion services" to list of covered inpatient ancillary services to align with Medicare payment policy	1